

AMENDMENT NO. \_\_\_\_\_

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Signature of Sponsor

**FILED**

Date \_\_\_\_\_

Time \_\_\_\_\_

Clerk \_\_\_\_\_

Comm. Amdt. \_\_\_\_\_

**AMEND Senate Bill No. 2798\***

**House Bill No. 3177**

by deleting all language after the enacting clause and by substituting instead the following:

Section 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 23, is amended by adding the following as a new section to be appropriately designated:

Section \_\_\_\_\_. (a) In addition to any other requirement of law concerning coverage of mental health or mental illness benefits, including but not limited to Section 56-6-2601, any group health plan issued by any entity regulated pursuant to insurance law under Title 56 shall provide coverage for mental health services as follows:

(1) As to either aggregate lifetime limits or annual limits or both, for a group health plan providing both medical and surgical benefits and mental health benefits:

(A) If the plan does not have a limit on substantially all medical and surgical benefits, the plan may not impose any such limit on mental health benefits;

(B) If the plan has a limit on substantially all medical and surgical benefits, the plan shall either include mental health benefits under the limit applied to medical and surgical benefits or apply a separate limit to mental health benefits that is no less than the one applied to medical and surgical benefits;

(C) If the plan has varying limits on different medical or surgical benefits, the plan shall apply an average limit to mental health benefits with the average to be computed based on the weighted average of the varying limits;

(D) "Aggregate lifetime limit" means a dollar limitation on the total amount that may be paid for benefits under a health plan with respect to an individual or other coverage unit; and

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(E) "Annual limit" means a dollar limitation on the total amount that may be paid for benefits in a twelve-month period under a health plan with respect to an individual or other coverage unit.

(2) (A) Any annual visit limits by a plan shall be equal to or greater than twenty (20) hospital inpatient days and twenty-five (25) outpatient or doctor visits. As an alternative to hospital inpatient days, if less costly residential treatment, partial hospitalization, or crisis respite care for the patient is appropriate, the plan shall provide for this care at the rate of two (2) alternate care days to one (1) day of inpatient hospital treatment.

(B) An issuer of a plan may not count toward the number of outpatient visits required to be covered under this subdivision an outpatient visit for the purpose of medication management and shall cover that outpatient visit under the same terms and conditions as it covers outpatient visits for the treatment of physical illness. Medication management shall not include services that could be billed as a therapy or consultation visit. For the purposes of this subdivision, "medication management" means pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.

(3) The mandate to provide coverage for mental health services at the same rates and terms as coverage provided for all medical and surgical conditions under this subsection shall not be applicable to services for the abuse of or dependency on alcohol or drugs.

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(4) A plan may not establish a separate limitation for mental health services for out-of-pocket cost sharing that is more costly than any such limitation applied to medical and surgical benefits.

(5) This subsection shall not apply to group health plans issued to small employers, defined as those with from two (2) to twenty-five (25) employees.

(b) Nothing in subsection (a) shall be construed as prohibiting an employee health benefit plan, or a plan issuer offering a group health plan from utilizing managed care practices for the delivery of benefits required under this section.

(c) Nothing in this section shall limit the amounts and terms of coinsurance, copayments, deductibles, or differentials required to be paid by the enrollee.

(d) The mandate to provide coverage for mental health services shall not apply with respect to a group health plan if the application of the mandate to such plan results in an increase in the cost under the plan of more than one percent (1%). Documentation of such increase in cost shall be filed with the department of commerce and insurance after twelve (12) months of experience. If the commissioner determines that such increase in cost is a result of the requirements of this section, the commissioner or the commissioner's designee shall issue a letter to the issuer of the plan that the plan does not have to comply with the mandate set out herein. The issuer may appeal the letter as final agency action pursuant to Title 4, Chapter 5.

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(e) The provisions of this section shall not apply to any individual policy issued under this title.

(f) The commissioner of commerce and insurance is authorized to promulgate rules and regulations to effectuate the purposes of this section. All such rules and regulations shall be promulgated in accordance with the provisions of Title 4, Chapter 5.

Section 2. Tennessee Code Annotated, Section 56-7-2601(a), is amended by adding the following new sentence immediately after the first sentence of the subsection: "The provisions of this subsection shall not apply to group policies or plans to which Section 1 of this act applies."

Section 3. Tennessee Code Annotated, Section 56-7-2601(g), is amended by deleting the language "In general," at the beginning of the subsection and by substituting instead the language "Subject to the provisions of Section 1 of this act, in general,".

Section 4. This act shall take effect on becoming a law for purposes of rulemaking, the public welfare requiring it. For all other purposes it shall take effect January 1, 2000, the public welfare requiring it. This act shall apply to contracts entered into or renewed on and after January 1, 2000.

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